

MISSOURI-DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-045757

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11535

FILED DEC 5 1963

1. PLACE OF DEATH

a. ~~XXXX~~ City of St. Louisb. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN St. Louis, Mo.Length of stay in 1b
39 Days2. USUAL RESIDENCE (Where deceased lived.. If institution: Residence - before admission)
a. STATE Mo. b. COUNTY St. Louis

c. CITY OR TOWN St. Johns Mo.

Inside Limits
Yes ☒ No ☐c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION

Firmin Desloge Hosp.

Inside Limits
Yes ☐ No ☐d. STREET ADDRESS (If outside, give location)
3535 CalvertReside on Farm
Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)First Middle Last
Johanna Genevieve McDonald

4. DATE OF DEATH

Month Day Year
11 20 63

5. SEX

Female

6. COLOR OR RACE
White7. Married ☐ Never Married ☐
Widowed ☒ Divorced ☐8. DATE OF BIRTH
11-3-849. AGE (last birthday)
79IF UNDER 1 YEAR
Months DaysIF UNDER 24 HR
Hours Min.10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
At Home10b. KIND OF BUSINESS OR INDUSTRY
At Home11. BIRTHPLACE (City and state or country)
St. Louis Mo.12. CITIZEN OF WHAT COUNTRY
U.S.A.

13a. FATHER'S NAME

(Harford, Thomas)

13b. MOTHER'S MAIDEN NAME

(Naughton, Katherine)

14. NAME OF HUSBAND OR WIFE
The Late Patrick J. Mc Donald15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, No or unknown) (If yes, give war or dates of)

No

No

16. SOCIAL SECURITY NO.

89A

17. INFORMANT

Catherine Mc Donald 3535 Calvert

18. CAUSE OF DEATH (Enter only one cause per
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Generalized sepsis

DUE TO (b)

Pneumonia

DUE TO (c)

perforated small bowel.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
11- general debilitated state 578x

INTERVAL BETWEEN ONSET AND DEATH

19. WAS AUTOPSY PERFORMED?
YES ☒ NO ☐

20a. ACCIDENT

SUICIDE

HOMICIDE

20c. TIME OF INJURY
Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐
NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

and last saw her alive on

Death occurred at

11-20-63 2:35 p.m.

on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

Phillip S. Daley, M.D.

22b. ADDRESS

Firmin Desloge Hospital

22c. DATE SIGNED

11-21-63

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE

11/23/63

23c. NAME OF CEMETERY OR CREMATORY

Calvary Cemetery

23d. LOCATION (City, town or county)

St. Louis Mo.

(State)

24. FUNERAL DIRECTOR

ADDRESS

Collier Mortuary, St. Ann, Mo.

25. DATE RECD. BY LOCAL REG.

NOV 21 1963

26. REGISTRAR'S SIGNATURE

Rosal Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

DATE AMENDED

VS 300
Rev. 4/59

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Sheldon Collier

Licensed Embalmer No.

3382

P. O. Address

St. Ann Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.